DEPARTMENT OF HEALTH AND HOSPITALS

Application for

Greater New Orleans Community Health Connection

No-cost health coverage for adults in the Greater New Orleans area

- Use this application to apply for the program called "Greater New Orleans Community Health Connection" (GNOCHC). You must reside in one of these parishes: Orleans, Jefferson, St. Bernard, or Plaquemines.
- Use only 1 application for each household.
- If you need extra space, use a separate sheet of paper.
- Use black ink.
- If you have questions, call us at **1-888-342-6207**.
- If you have questions and use a TTY text telephone, call us at **1-800-220-5404**.

Where to send your application:

- If you are at a clinic, give the completed application to a clinic worker.
- Fax the completed application to **1-866-861-6018**.
- Mail your completed application to: **Orleans Regional Medicaid**
  P.O. Box 60840
  New Orleans, LA 70160

What is the patient's preferred language? ☐ English ☐ Vietnamese ☐ Spanish ☐ Other: _____

Section 1 Contact Information

Mailing Address			**Home Address (if different)** ☐ **Check here if same as Home Address. If different, tell us below.**		
P.O. Box or Street Address		Apt/Lot #	Street Address		Apt/Lot #
City	State	Zip	City	State	Zip
Home Parish ☐ Orleans ☐ Jefferson ☐ Plaquemines ☐ St. Bernard ☐ Other:					
Home Phone ( )	Cell Phone ( )		E-mail Address (if you have one)		

For Agency Use

AC Center _____ AC ID _____ AC Rep _____

Section 2 People living in your home

Tell us about you, your spouse and children under age 19.

	You	Spouse	Child 1	Child 2
Relation to you	☒ Self	☐ Spouse	☐ Child ☐ Step-child ☐ Grandchild ☐ Other:	☐ Child ☐ Step-child ☐ Grandchild ☐ Other:
First name, Middle initial				
Last name (Suffix: Sr., Jr., etc.)				
Social Security Number				
Date of birth (month/day/year)				
Race (Optional—you may mark one or more)	☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native Tribe: ___________ ☐ Other: ___________	☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native Tribe: ___________ ☐ Other: ___________	☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native Tribe: ___________ ☐ Other: ___________	☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native Tribe: ___________ ☐ Other: ___________
Is this person Hispanic or Latino? (Optional)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Does this person want to apply for coverage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this person have health insurance?	☐ Yes — Is the insurance through a job? ☐ Yes ☐ No ☐ No — Is insurance available through a job? ☐ Yes ☐ No	☐ Yes — Is the insurance through a job? ☐ Yes ☐ No ☐ No — Is insurance available through a job? ☐ Yes ☐ No	☐ Yes — Is the insurance through a job? ☐ Yes ☐ No ☐ No — Is insurance available through a job? ☐ Yes ☐ No	☐ Yes — Is the insurance through a job? ☐ Yes ☐ No ☐ No — Is insurance available through a job? ☐ Yes ☐ No
Has health insurance ended for this person in the past 12 months?	☐ Yes ☐ No When?	☐ Yes ☐ No When?	☐ Yes ☐ No When?	☐ Yes ☐ No When?
A disability is a physical or mental impairment that lasts for at least one year or is expected to result in death.				
Does this person have a disability?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
The answers you give about citizenship are kept private.				
Is this person a U.S. citizen?	☐ Yes – Skip to Section 3 ☐ No – Keep Going	☐ Yes – Skip to Section 3 ☐ No – Keep Going	☐ Yes – Skip to Section 3 ☐ No – Keep Going	☐ Yes – Skip to Section 3 ☐ No – Keep Going
Is this person a lawful permanent resident?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
When was this person granted residency?				
Permanent Resident Card #				
Alien #	A	A	A	A

Section 3 Income from a job (Examples: cash, checks, tips)

Do parents or children in the home work? ☐ Yes—Tell us about it below. ☐ No—Skip to Section 4.
Please list each job. Do not include income of grandparents or other non-parent caregivers.

Worker's Name	**Employer Name & Phone Number**	**Is this person self-employed?**	**How much?** (Gross income before taxes)	**How often?** (Weekly, every 2 weeks, twice a month, monthly)
		☐ Yes ☐ No	$	
		☐ Yes ☐ No	$	
		☐ Yes ☐ No	$	

Section 4 Other Income (Examples: Social Security, alimony, unemployment, workers' comp, child support)

Do parents or children in the home get income that is not from a job?
☐ Yes—Tell us about it below. ☐ No—Skip to Section 5.
If the income is child support, list the child as the person who gets it.

Who gets it?	**From where?**	**How Much?** (Gross income before taxes)	**How Often?** (Weekly, every 2 weeks, twice a month, monthly)
		$	
		$	
		$	

Section 5 Expenses

Tell us about expenses for parents and their children in your home.

Expense	**Who pays for it?**	**How much each month?**
Court ordered child support? ☐ Yes ☐ No		$
Court ordered alimony? ☐ Yes ☐ No		$
Care for a child or for a person with a disability? ☐ Yes ☐ No Who gets care? _____		$

Section 6 Medical Expenses

Does anyone listed on this application have bills (paid or unpaid) for medical care they received in the past 3 months? ☐ Yes – Tell us about it below. ☐ No – Skip to Section 7.

Who received care?	**Name and phone number of doctor, clinic, or other medical provider**	**What was the date of service?**	**Total Cost**

Section 7 Other

Is any applicant in the home pregnant?	☐ Yes ☐ No	Who is pregnant? Expected Due Date:
Does any applicant have Medicare?	☐ Yes ☐ No	Who has Medicare?
Has any applicant had Medicaid before?	☐ Yes ☐ No	Who needs a new card?

Section 8 Things you own

Only complete this section if someone applying is over age 65 or has a disability.
A disability is a physical or mental impairment that lasts for at least 1 year or is expected to cause death.

Things you own	**Who owns it?**	**Bank Name or Description of Item**	**What is it worth?**
Bank accounts? ☐ Yes ☐ No			$
Certificates of Deposit (CD)? ☐ Yes ☐ No			$
Annuities, stocks, bonds, mutual funds, retirement accounts? ☐ Yes ☐ No			$
Property other than your home (like inherited or vacation home)? ☐ Yes ☐ No			$
Life or burial insurance? ☐ Yes ☐ No			$
Pre-need or money set aside for burial? ☐ Yes ☐ No			$
Vehicles (cars, trucks, boats, campers, motorcycles, ATV's)? ☐ Yes ☐ No			$
Safety deposit box? ☐ Yes ☐ No			$
A trust? ☐ Yes ☐ No			$
Other? (please be specific) ☐ Yes ☐ No			$

This is the end of the application. Read and sign below.

By signing this application I am giving my permission to the State of Louisiana and its agents to make contacts to verify the information given on this application. Under penalty of perjury, I certify that all information contained in this application, including U.S. citizenship or lawful immigrant status of all persons applying for benefits, is true and correct to the best of my knowledge. I have read or someone has read to me the "Rights and Responsibilities" section of the application, including fraud penalties.

Sign Here:	**Date:**
Spouse Signs Here (if applying):	**Date:**

Rights and Responsibilities	
What the Louisiana Department of Health and Hospitals (DHH) has the right to expect of you	
Changes	You agree to tell DHH within 10 days of these changes: 1) if anyone getting medical care moves out of state; 2) if anyone moves in or out of the home; 3) if there are changes in your mailing or home address; or 4) if there are changes in health insurance and premiums or if anyone gets health insurance.
Reporting the truth	You state that answers you gave on this application are true and correct. If you purposely gave information that is not true or if you withheld information, you have committed fraud. If you commit fraud, you may have to pay back money that DHH pays for care that you receive.
Social Security numbers	You understand Social Security numbers will only be used to get information from other government agencies to see if you qualify for services.
Payment of medical care by a third party	By accepting medical care, you understand that DHH has the right to get money received by you from other sources like insurance payments or lawsuit settlements for care that DHH has paid for you.
Child Support Enforcement	You understand that DHH will only send case information to Child Support Enforcement for medical support if you ask them to. DHH will make a referral only if parents of children under age 19 get Medicaid. You can request that DHH not refer you to Child Support Enforcement if you feel you have good cause not to cooperate with Support Enforcement.
What you have the right to expect from DHH	
Your right to a fair hearing	You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.
DHH cannot discriminate	You understand DHH cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818, Baton Rouge, LA 70821-4818.
Other services	You understand that information about WIC, KIDMED, and other programs may be sent to anyone who qualifies.

Things we may ask for
Copies of all health insurance cards (front and back)
For non-U.S citizens: copies of Permanent Resident Cards or other forms from U.S. Citizenship and Immigration Services
For anyone who works: proof of income such as last month's pay stubs or a letter from the employer
For self-employment: copies of last year's tax return with all schedule attachments
For income that is not from a job (Examples: VA, worker's comp, unemployment, child support, alimony): proof of income like award letters or 1099 tax statements from last year's tax return
Letter from friend or relative who gives you money
Proof of payments made for care given to children or to anyone with a disability
Court order and proof of child support or alimony payments made to anyone outside the home
Proof of the value of things you own like bank statements, insurance policies, burial contracts, savings bonds, stock certificates, trust documents, or succession documents